

# NOTIFICATION OF INJURY

# The Texas A&M University System

**WARNING:** Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

- A. EXCESS COVERAGE** – Eligible covered expenses will be paid only if they are in excess of other valid and collectible insurance or medical payment plan, regardless of any Coordination of Benefits provision contained in such plan. If the claimant is covered by any other insurance or medical plan they must submit a claim to their primary insurance first. After the primary insurance has paid benefits, then submit this claim form along with all EOB's (explanation of benefits) from the primary insurance.
- B.** Attach all medical bills. All bills submitted must be **ITEMIZED** for service. A balance due statement is not acceptable. A physician's office should submit an invoice per HCFA 1500. A hospital should submit an invoice per UB92. HCFA 1500 and UB92 are universal billing forms.
- C.** The Claim must be submitted **within 90 DAYS** from the date of the accident.
- D.** Forward additional bills as they are received. No additional claim form needed. *Keep copies of everything.*

**CLAIM FILING: (Mail or Fax to)** Southwest Special Risk Insurance, 3116 W. 5<sup>th</sup> Street, Suite 106, Fort Worth, Texas 76107. Fax No.: (817) 336-9967. For claim filing questions, please call (817) 923-1111.

**CLAIM STATUS:** To check the status of a claim, please call (800) 955-1991.

<b>PART A – This PART MUST be completed, dated and signed by an official or the Organization.</b>			
1. Name of Organization (Policyholder) <b>The Texas A&amp;M University System</b>			
2. Policy No. <b>US003614</b>			
3. Name of Organization or Team (if Different from Policyholder) <b>Institution/Agency Name: _____</b> <b>Camp Name:</b>			
4. Address or Organization:                      (Street)    (City)    (State)                      (Zip)			
5. Name of Injured Person (Insured)?    (First)    (Middle)    (Last)			
6. Date of Accident/Injury Mo.                      Day                      Year		7. Injury Occurred: Practice <input type="checkbox"/> Travel <input type="checkbox"/> Game <input type="checkbox"/> Other:	
8. Type of Sport or Activity:			
9.. Explain <b>HOW</b> the accident and injury occurred. <b>NOTE:</b> If your organization uses an Accident Report, attached a copy of the Report.			
10. Describe the nature of injury.			
11. At the time of the accident, was the Person involved in an activity under the jurisdiction of the Organization (Policyholder)? Yes <input type="checkbox"/> No <input type="checkbox"/>		12. Name of Supervisor of Activity.	
13. Was he/she a witness to the injury? Yes <input type="checkbox"/> No <input type="checkbox"/>			
14. Signature of Organization Official  <b>X</b> _____		15. Title of Official	
16. Area Code/Telephone No.		17. Date Signed	

**PART B** – This PART **MUST be completed, dated and signed** by the injured Person – or if the injured Person is under the age of 18 or otherwise dependent – by his/her Parent or Guardian.

Print Here – NAME OF PERSON COMPLETING FORM

Circle One: Injured Person  Parent  Guardian

**Give the following information about the injured person:**

1. Date of Birth  
Mo. Day Year.

2. Male   
Female

3. Social Security No. or Student Visa No.

4. Area Code/Telephone No.

5. Address: (Street) (City) (State) (Zip)

6. Employer (Name) (Street) (City) (State) (Zip)

Area Code/Telephone No.

7. Is the injured Person covered under any other health and/or accident insurance plan? Yes  No   
If YES, give the following information:

Name of Policyholder(s) Address of Other Insurance Company Policy Number(s) Name of Insurance Company(s)

8. If the Injured Person is under 18 or otherwise dependent, give the following information:

Name of Father or Male Guardian Social Security No.

Place of Employment

Address of Employer Area Code/Employer Phone No.

Name of Mother or Female Guardian Social Security No.

Place of Employment

Address of Employer Area Code/Employer Phone No.

9. If the Injured Person is married, give the following information:

Name of Spouse Social Security No.

Place of Employment

Address of Employer Area Code/Employer Phone No.

I hereby authorize any Health Care Provider, Insurance Company, Employer, Person or Organization to release information regarding medical, dental, mental, drug or alcohol history, treatment or benefits payable, including disability or employment related information, to Summit America Insurance Services, L.C., the Plan Administrator or their employees and authorized agents for the purpose of validating and determining benefits payable. Any information obtained will not be released by the Company except to persons or organizations performing business or legal services in connection with my application or claim. A photocopy of this authorization shall be valid as the original and is valid for 24 months from the date shown below. I understand that I or my authorized representative will receive a copy of this authorization upon request.

**X** \_\_\_\_\_  
Signature (in writing) of Responsible Party

\_\_\_\_\_ Print Name

Mark One

Injured Person  
 Parent Date \_\_\_\_\_  
 Guardian